GREAT LAKES EYE
Institute
Eye Clinic and Surgery Center

Farhad K. Shokoohi M.D., F.A.C.S.
Retina and Vitreous Diseases and Surgery

John M. O'Grady, M.D.
Cataract, Glaucoma, and Refractive Surgery

Majed Sahouri, M.D.
Comprehensive Ophthalmology

Kamran K. Shokoohi, M.D., Ph.D.
Retina/Vitreous Diseases and Surgery
Comprehensive Ophthalmology

David W. Blodgett, M.D.
Neuro-Ophthalmic Plastic Reconstructive Surgery

Daniel J. Lin, M.D.
Neuro-Ophthalmic Plastic Reconstructive Surgery

Richard A. Kaiserman, M.D.
Cataract Surgery
Comprehensive Ophthalmology

Brian D. Dudenhoefer, M.D.
Cataract Surgery
Comprehensive Ophthalmology

Michael P. Mesaros, M.D., F.A.C.S.
Comprehensive Ophthalmology

Moonyoung S. Chung, M.D.
Cornea
Comprehensive Ophthalmology

Patrick J. Bell, O.D.
Comprehensive Optometry

Bart Darnell, O.D.
Comprehensive Optometry

Kristine M. Weaver, O.D.
Comprehensive Optometry
Low Vision

GREAT LAKES EYE INSTITUTE

AUTHORIZATION FORM TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

PLEASE READ THIS DOCUMENT CAREFULLY

Name of Patient: _____ **DOB**_____

This is an authorization form that will permit Great Lakes Eye Institute ("Covered Entity") to use or disclose some of your protected health information. Covered Entity will not condition treatment on whether you sign this authorization. You have the right to revoke this authorization at any time by sending a *written* revocation to:

Privacy Official: Farhad Shokoohi, MD, GLEI, 2393 Schust Road, Saginaw, MI 48603

Your revocation will not apply, however, to uses and disclosures Covered Entity has already made in reliance on your authorization.

I authorize Covered Entity to use /disclose/receive the following health information about me (Name and address of entity or persons to release records and what specific records are to be released.)

_____
_____
_____

To the following entity or persons:

(Name and address of entity or persons to receive records):_____
_____
_____
_____

Purpose of disclosure:

_____

This authorization allows GLEI to release **all** records as requested **including** records on mental health, substance abuse, HIV, and sexually transmitted disease, unless this authorization specifically restricts release of such records.

Restrictions (if any): _____

This authorization is valid until _____**, 20___.**

Please provide the following information if you are a personal representative of a patient of Covered Entity:

1. Your printed name:_____
2. Description of personal representative's authority:_____
3. Where applicable, Guardianship and or Power of Attorney documentation must be provided to Covered Entity before release of PHI can be granted.

Please Read Carefully and Sign

I understand that Covered Entity will use or disclose my health information as described above until this authorization expires. I understand that I will receive a copy of this signed authorization for my records. I also understand that any health information released pursuant to this authorization might be re-disclosed by the recipient, and that any such re-disclosure may not be protected by law.

_____ _____
Patient's Signature (or Guardian's Signature) Date